

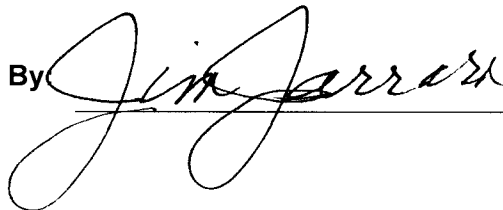
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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

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<b>Section:</b>	Community Policy Management Section	<b>Effective Date:</b>	1/1/2011
<b>Team:</b>	LME Team	<b>Policy No.</b>	LME 102
<b>Subject:</b>	Endorsement Policy	<b>Revision date :</b>	

**Approved By**



**Approval Date:**

12/21/10

**Purpose:**

The purpose of the endorsement policy is to establish a statewide system for assuring that providers of mental health, developmental disabilities and substance abuse (mh/dd/sa) services meet qualifications required to be eligible to receive Medicaid funding. This system ensures that individuals receive services and supports from providers that comply with state and federal laws, rules, regulations, quality standards and policies.

**Scope:**

This policy applies to all providers of Medicaid-reimbursable mh/dd/sa services who are required by the North Carolina State Plan for Medical Assistance under Title XIX of the Social Security Act (NC State Plan) to be endorsed prior to enrollment in the NC Medicaid program. Hospitals and academic institutions requesting to provide a service(s) are also subject to the endorsement process.

Those provider organizations wishing to provide Intensive In-Home, Child and Adolescent Day Treatment, Community Support Team, Peer Supports, or Targeted Case Management Services for mh/sa consumers must also be certified as a Critical Access Behavioral Health Agency (see LME 101, DMH/DD/SAS CABHA Certification Requirements Policy).

**Policy Statement:**

It is the policy of DMH/DD/SAS that all providers requesting enrollment in the NC Medicaid Program to provide mh/dd/sa services must be assessed by qualified reviewers prior to enrollment to ensure that they meet objective criteria, including compliance with all state and federal laws, rules, and regulations, and have the capacity to sustain quality service delivery. Endorsement is intended to ensure that a provider meets qualification requirements prior to the initiation of service delivery. Accreditation by an approved national accrediting body within one year of enrollment with the Division of Medical Assistance (DMA), or one year after the National Accreditation requirement becomes applicable to that service, is required to ensure that providers continue to conform to quality standards. Continued provider compliance is reviewed on an ongoing basis through a system of monitoring, licensing, and auditing that can impact a provider's endorsement and/or Medicaid enrollment status.

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

**Enforcement:**

The Local Management Entity (LME) Team is responsible for enforcement of this policy.

**Exceptions:**

None. However, this policy does not apply to an LME with a Centers for Medicare and Medicaid Services (CMS) approved waiver.

**Definitions:**

As used in this policy the following terms have the meanings specified:

- (1) **“Business Entity”** means the business management component of the provider organization. The business entity may be located in the same physical location as the provider organization or it may be in a different physical location.
- (2) **“Business Entity Verification”** means to confirm the completeness and accuracy of the business entity information as required on the application.
- (3) **“Check Sheet”** means the list of requirements, per each service definition, that shall be met in order to obtain endorsement (check sheets are available on the DMH/DD/SAS website at <http://www.ncdhhs.gov/mhddsas>).
- (4) **The Community Alternatives Program for Persons with Mental Retardation/ Developmental Disabilities (CAP-MR/DD)** - a Medicaid waiver program to serve individuals who would otherwise require care in an intermediate care facility for people with mental retardation/developmental disabilities (ICF/MR). It allows these individuals the opportunity to be served in the community instead of residing in an institutional setting.
- (5) **“Community Intervention Services (CIS) Agency”** – means a provider agency classification confirming that the agency has met the eligibility criteria for entering into a participation agreement with the Division of Medical Assistance to provide certain specific services that have been endorsed or approved by the LME, or the DMH/DD/SAS in the case of an LME, responsible for determining such eligibility. Once approval or endorsement has been awarded, the service provider agency may then achieve approved status as a Medicaid Provider of Community Intervention Services and enter into a participation agreement with the Division of Medical Assistance to provide the services.
- (6) **“Core Rules”** means those general rules identified in Rules 10A NCAC 27G .0100-.0900, governing mh/dd/sa services, for both facilities and agencies providing such services, and the Local Management Entities administering such services within the scope of N.C.G.S. §122C.
- (7) **“Critical Access Behavioral Health Agency” (CABHA)** means a Critical Access Behavioral Health Agency certified pursuant to LME 101, DMH/DD/SAS CABHA Certification Requirements Policy.

---

**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

- (8) **“Endorsement”** means a verification and quality assurance process using statewide criteria and tools set out in this Policy to determine the competency and quality of a provider of mh/dd/sa services.
- (9) **“Endorsing Agency”** means the entity, whether it is the Local Management Entity or DMH/DD/SAS, which has the statutory responsibility to endorse and/or withdraw endorsement of a provider organization for the provision of a service.
- (10) **“Good Standing – Department of Health and Human Services (DHHS)”**

A provider is not in good standing with the DHHS if any of the following conditions are present, regardless of any appeal filed by the provider:

- (a) The provider owes an outstanding accounts receivable to the DHHS, including but not limited to Medicaid overpayments, cost settlements, penalties and interest. An outstanding account is one that is more than thirty days past due from the date of notification. A provider that entered into an approved payment plan in accordance with Rule 10A NCAC 22F .0601(a), and who has made all payments on time and in full, and has met all other requirements that may be in the payment plan agreement, is considered to be in good standing;
- (b) The provider is required to submit its Medicaid claims for prepayment claims review to DMA or its contractor;
- (c) The current owners, operators, or managing employee(s) of the provider agency were previously the owners, operators, or managing employee(s) of a provider agency which had its participation in the N.C. Medicaid program involuntarily terminated for any reason or owes an outstanding accounts receivable to the DHHS, irrespective of whether the provider agency is currently enrolled in the N.C. Medicaid program;
- (d) The provider and its owners, operators and managing employee(s) are listed on the U.S. Department of Health and Human Services Office of Inspector General Exclusion list;
- (e) The provider, or its corporate parent, has unresolved tax or payroll liabilities owed to the U.S. or N.C. Departments of Revenue or Labor;
- (f) The provider abandoned or destroyed patient medical records or staff records in violation of federal or state law, rule or regulation;
- (g) The current owners, operators, or managing employee(s) of the provider agency were previously the owners, operators, or managing employee(s) of a provider agency which abandoned or destroyed patient medical records or staff records in violation of federal or state law, rule or regulation;
- (h) The provider has an open Plan of Correction (POC) with the DMH/DD/SAS Accountability Team. A POC must be timely submitted, approved, and implemented before the POC action can be closed. A POC is fully implemented when the POC is being followed and all out of compliance findings have been minimized or eliminated as determined by DMH/DD/SAS in a maximum of two follow-up reviews. The POC action is closed when the provider receives the official notification from the DMH/DD/SAS Accountability Team stating the action is closed;
- (i) If the provider is subject to licensure requirements, the provider fails to meet any of the requirements for enrollment and/or licensure set forth in N.C.G.S. §122C-23(e1).

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

- (j) Where the provider is incorporated, or where otherwise applicable, the provider fails to maintain, and produce upon request, a current, valid Certificate of Existence issued by the NC Secretary of State's Office.

**“Good Standing – LME”**

The provider is in good standing with the LME if the provider organization has a history of compliance with Clinical Policy specific to service delivery and does not have an open POC with the LME. A POC must be timely submitted, approved, and implemented before the POC action can be closed. A POC is fully implemented when the POC is being followed and all out of compliance findings have been minimized or eliminated as determined by the LME in a maximum of two follow-up reviews. The POC action is closed when the provider receives the official notification from the LME stating the action is closed.

- (11) **“Legally Constituted Entity”** means a for-profit corporation or nonprofit corporation as defined in N.C.G.S. § 55-1-40 that is entitled or required to submit filings to the Department of the Secretary of State pursuant to N.C.G.S. § 55D-10 and is currently active and in good standing in its filings with the Secretary of State's Office, or a business entity that is not incorporated but is registered with the local municipality.
- (12) **“Local Management Entity” or “LME”** means the same as defined in N.C.G.S. § 122C-3(20b).
- (13) **“Notification of Endorsement Action” or “NEA”** means the state approved standardized document which notifies the provider of the status of its endorsement.
- (14) **“Provider”** means the provider organization entity, or agency (regardless of corporate structure) that is seeking endorsement to provide the service; this also includes the corporate parent of such organization, entity, or organization.
- (15) **“Qualified Reviewer”** means staff employed by the endorsing agency with knowledge and expertise about the DHHS Policy and Procedures for the Endorsement of Providers of Medicaid Reimbursable Services and its implementation. Staff should also have knowledge and expertise related to provider qualifications, staffing requirements, service requirements as well as clinical and documentation requirements.
- (16) **“Resolved”** means the oversight agency is in receipt of a Final Agency or court decision or other documents showing that the outstanding or unresolved action has been closed and all implementation and follow-up reviews have been completed. Pursuant to N.C.G.S. § 150B-45, any party wishing to appeal the Department of Health and Human Services' Final Agency Decision may commence such an appeal by filing a Petition for Judicial Review in the Superior Court of Wake County or in the Superior Court of the county in which the party resides. The party seeking review must file the petition within 30 days after being served with a written copy of the DHHS Decision and Order.
- (17) **“Site” or “Site Location”** means an administrative office at or from which mh/dd/sa services are provided, records necessary to support current and the previous six years' billing of services are maintained, staffing records are maintained and/or supervisory or billing activity occurs (not to

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

include third party billing agents), including but not limited to the corporate headquarters and any location from which staff are based to deliver services in the community. The corporate office must be registered with the Secretary of State and with the local municipality when applicable. The site cannot be a private home unless the agency is only providing residential services (e.g., a Level III group home could not have an office for periodic services at the same address). The site cannot provide other services that are not regulated by DHHS, its Divisions, or a Local Management Entity (e.g., a hair salon cannot be at the same address as the provider agency).

- (18) **“Site/Service Endorsement”** means the review and approval of a site to provide a service or services to be delivered at a specific site.
- (19) **“Standard Agreement”** means the document approved by the state for statewide use which sets forth the expectations and responsibilities of the provider organization and the endorsing agency and has been signed by the parties. It is effective for a three year period and is also referred to as a Memorandum of Agreement (MOA).
- (20) **“Substantial Failure to Comply”**, as defined in Rule 10A NCAC 26C .0502, means evidence of one or more of the following:
  - (a) The provider has not addressed issues that endanger the health, safety or welfare of the individual(s) receiving services;
  - (b) The provider has been convicted of a crime specified in G. S. 122C – 80;
  - (c) The provider has not made available and accessible all sources of information necessary to complete the monitoring processes set out in N.C.G.S. § 122C – 112.1;
  - (d) The provider has created or altered documents to avoid sanctions;
  - (e) The provider has not submitted, revised or implemented a plan of correction in the specified time frames; or
  - (f) The provider has not removed the cause of a summary suspension within the specified time frame.

**Procedure:**

**1. Business Entity Verification and Renewal**

Endorsement consists of two parts: business entity verification and site/service endorsement.

Business entity verification must take place prior to site/service endorsement. The provider shall submit to the endorsing agency, in whose catchment area the corporate office or the statewide headquarters is located, a correct and complete DMA Provider Enrollment Application with supporting documentation. The business entity verification shall be conducted by only one endorsing agency. The provider shall also submit to the endorsing agency documentation that the business entity is currently registered with the local municipality or the office of the NC Department of the Secretary of State, that the information registered with the local municipality or the Secretary of State is current and that there are no dissolution, revocation or revenue suspension findings currently attached to the provider entity. The provider agency must be a legally constituted entity. In addition, the provider shall submit documentation that the business entity is in good standing with the U.S. and N.C. Departments of Revenue and Labor.

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

The provider shall also submit service related documents (i.e., program description, job description, program schedule, etc.) in the event the provider chooses to seek site/service endorsement in the same catchment area in which the provider is seeking business entity verification. Documents related to service delivery will be reviewed by the endorsing agency at the desk review. Simultaneously, the provider may, but is not required to, submit a written explanation describing the need for the service in the endorsing agency's catchment area. While this written explanation is encouraged, its submission is optional. As such, neither its content nor a provider's choice not to submit it, shall be used by the endorsing agency to delay or terminate the endorsement process. Likewise, where submitted, the written explanation is subject only to review, not approval, by the endorsing agency, and shall not be used as a basis to deny endorsement.

Where applicable, the provider shall also submit a completed Core Rules Self-Study (i.e., checklists) along with supporting documentation. The business entity shall comply with Rule 10A NCAC 27G .0201, Governing Body Policies. This packet shall serve as the application for endorsement with the endorsing agency.

The self-study is **not** required if:

- (1) The business entity is accredited by an accrediting agency, approved by the Secretary of DHHS, such as the Council on Accreditation (COA), the Council on Quality and Leadership (CQL), the Council on Accreditation of Rehabilitation Facilities (CARF), or the Joint Commission; or
- (2) At least one mh/dd/sa service offered by the provider is provided in a facility licensed in accordance with N.C.G.S. § 122C; or
- (3) At least one of the services already offered by the provider is provided in a facility licensed under N.C.G.S. § 131D and an endorsing agency has conducted a review within the last twelve months and determined the provider is in compliance with the requirements of the core rules; or
- (4) The endorsing agency or a contract agency of the endorsing agency, or a like entity, has conducted a review within the last 12 months and determined the provider is in compliance with the requirements of the core rules.

Upon receipt of the application for endorsement, the endorsing agency shall review the submitted information against any and all public databases, including businesses registered with the local municipalities and/or the list of corporations registered with the North Carolina Secretary of State as corporations and shall verify the name, business status and address of the provider. The endorsing agency shall evaluate the core rules self-study checklists and supporting documents, where applicable, for correctness and completeness. In addition, the endorsing agency shall also check DHHS and/or other State agency records concerning violations by and actions against the provider to ensure that the provider is in good standing with DHHS and/or other LMEs. If prior to granting business entity verification it is determined that the provider agency is not in good standing with DHHS and/or any LME, the endorsing agency shall terminate the business entity verification process. The provider may reapply at any time after good standing with DHHS and/or LME(s) has been re-established. If the provider organization determines that it will re-apply, the provider organization must initiate the process by submitting the complete application to the endorsing agency.

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

The endorsing agency shall notify the provider regarding the status of the business entity verification review via return receipt/certified mail within 20 calendar days following the receipt of the endorsement application. If additional information is needed, the provider will have 10 calendar days to submit those materials to the endorsing agency; the additional materials must be submitted via return receipt/certified mail. If the 10 calendar day timeline is met, the endorsing agency will evaluate the materials to determine if they are complete and correctly done; the endorsing agency shall then notify the provider, within 10 calendar days, via return receipt/certified mail, regarding the status of the business entity verification review. If the required information is not received within the 10 calendar day timeline, the endorsing agency must notify the provider via return receipt/certified mail that the information was not timely received and is not subject to review. A provider who wishes to continue with the endorsement process must resubmit the entire application packet updated to include the additional materials required, and restart the process.

The business verification notification (NEA) letter shall specify one of the following actions:

- (1) Provider meets business entity verification requirements and business entity verification is granted; or
- (2) Provider does not meet business entity verification requirements and business entity verification is denied; the notice of denial shall include a statement of the provider's appeal rights at the local and state level.

Business entity verification status is valid for up to three years. In order to renew business entity verification at the end of this time period, the provider shall submit to the endorsing agency a copy of the National Accreditation Certificate, a standardized re-endorsement Letter of Attestation that includes the current business information (i.e., name, business status, and address), and a report of any dissolutions, revocations, or revenue suspensions that have occurred over the past three years. This documentation must be submitted via return receipt/certified mail.

The provider shall submit the above mentioned information to the endorsing agency that granted the provider's business entity verification at least 30 calendar days prior to the expiration of the current endorsement. The endorsing agency shall review the information submitted as well as any adverse actions, sanction activity and monitoring results involving the provider. The endorsing agency has the authority and the discretion to conduct an onsite review(s) based upon the information contained in the standardized re-endorsement Letter of Attestation.

If the information submitted meets endorsement requirements, the endorsing agency shall renew the standard MOA with the provider for three years. The provider must notify the endorsing agency immediately if at any time the provider's national accreditation status lapses or is withdrawn. Loss of national accreditation for the affiliated business entity shall lead to withdrawal of endorsement for mh/dd/sa services that require accreditation.

A provider that fails to submit the standardized re-endorsement Letter of Attestation or that provides false or misleading information in the standardized re-endorsement Letter of Attestation to the endorsing agency shall have its agency's business entity verification involuntarily withdrawn. The endorsing agency shall notify DMA via an NEA letter that the business entity verification has expired and has not been renewed because of failure to submit the re-endorsement Letter of Attestation and/or because the provider submitted false or misleading information in the re-endorsement Letter of Attestation.

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

## **2. Service Endorsement**

Service endorsement is site and service specific and shall be honored by all endorsing agencies. The provider must successfully complete three steps in order to achieve site/service endorsement:

- (a) Desk Review of documents related to service specific check sheets
- (b) Clinical Interview
- (c) Onsite Review

### **2A. Desk Review**

The endorsing agency shall perform a desk review of each service the provider seeks to provide within 20 calendar days from the date the endorsing agency sends notification that the provider organization meets business entity verification requirements.

In the event the provider has been granted business entity verification but chooses not to provide a service in the catchment area in which the business entity verification was granted, the provider shall submit an application for endorsement to the endorsing agency where the service/site will be located. Documents related to the service(s) the provider seeks to deliver (i.e., program description, job description, program schedules, etc.) shall be submitted with the application for endorsement. The endorsing agency shall perform a desk review of each service the provider seeks to provide within 20 calendar days of the receipt of the provider's application.

The endorsing agency shall use the standardized NC DHHS – DMH/DD/SAS Endorsement Check Sheets to complete the desk review. The standardized check sheets can be found at [www.ncdhhs.gov/mhddsas](http://www.ncdhhs.gov/mhddsas).

The desk review shall include a review of documents related to:

- (1) Business Entity Verification requirements (note – the endorsing agency only confirms that the provider has met business entity verification requirements)
- (2) CABHA certification where applicable
- (3) Staffing requirements
- (4) Policy and Procedure Manual
- (5) Personnel Manual
- (6) Job descriptions
- (7) Service type/setting requirements
- (8) Program description
- (9) Clinical requirements
- (10) Documentation requirements

In all situations where the provider has not previously provided the service(s) and, therefore, has no completed consumer records the endorsing agency shall complete the desk review using the check sheets excluding those items requiring components of consumer records.

If at any time during the endorsement process it is determined that the provider agency is not in good standing with DHHS and/or any LME, the endorsing agency shall terminate the endorsement process. The provider may reapply at any time after good standing with DHHS and/or LME(s) has been re-

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

established. If the provider organization determines that it will re-apply, the provider organization must initiate the endorsement process by submitting the complete endorsement application to the endorsing agency.

The endorsing agency shall notify the provider of the status of the desk review portion of the endorsement review within 10 calendar days following the desk review. The notification letter shall specify one of the following actions:

- (1) Provider meets desk review requirements and the clinical interview is scheduled; or
- (2) Provider is not in compliance with the requirements to provide the service(s) for which application was made and site/service endorsement is denied.

The notice of denial shall include a statement of the provider's appeal rights at the local and state level.

Currently enrolled and active DHHS Community Intervention Services (CIS) and CAP-MR/DD providers who wish to add a service to the existing location must first complete the CIS or CAP-MR/DD Addendum form and submit the completed form to the endorsing agency. Applications submitted to add a service shall not be processed if the provider is not in good standing with DHHS and/or any LME.

## **2B. Clinical Interview**

The endorsing agency shall complete the clinical interview within 20 calendar days of the notification of the completion of a successful desk review.

The purpose of the clinical interview is to determine the clinical expertise and skill level of the provider's staff as well as their knowledge and understanding of the age and disability (i.e., mh/dd/sa) characteristics of the individuals they seek to serve. The provider shall hire all staff members to meet the staffing requirements of the service definition for which the provider is seeking to become endorsed by the date of the clinical interview. Prior to the clinical interview, the endorsing agency staff shall review the qualifications of the staff members hired to meet the staffing requirements of the service definition. If any staff person hired to meet the staffing requirements of the service definition does not meet the requirements for the position, then the clinical interview will be canceled and endorsement denied.

The clinical interview shall be completed by at least two licensed clinicians (as defined in Rule 10A NCAC 27G.0104) of the endorsing agency. The clinical interview may, at the sole discretion of the endorsing agency, occur at the provider site/office or the endorsing agency office. An MD or PhD from the endorsing agency shall be present if the provider representative is an MD or PhD. The Clinical Director of the endorsing agency shall not be included in the team of two licensed clinicians completing the clinical interview as the Clinical Director may be involved in the appeal process at the local level.

All provider staff hired to meet the staffing requirements of the service definition shall participate in the clinical interview unless otherwise noted in the standardized endorsement check sheet and instructions. The provider staff shall be asked questions from a checklist of standardized clinical questions. The standardized clinical questions check sheets can be found at [www.ncdhhs.gov/mhddsas](http://www.ncdhhs.gov/mhddsas). At the sole discretion of the endorsing agency, the interview team may ask additional questions not identified on the check sheets during the interview to clarify a response made by the provider agency staff.

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

The licensed clinicians, of the endorsing agency, that conducted the clinical interview shall make the decision regarding the provider's qualifications and readiness to provide the service(s) requesting endorsement by rating the clinical interview requirement as met or not met pursuant to the *Endorsement Clinical Interview Guidelines*. The *Endorsement Clinical Interview Guidelines* can be found at [www.ncdhhs.gov/mhddsas](http://www.ncdhhs.gov/mhddsas).

If at any time during the endorsement process it is determined that the provider agency is not in good standing with DHHS and/or any LME, the endorsing agency shall terminate the endorsement process. The provider may reapply at any time after good standing with DHHS and/or LME(s) has been re-established. If the provider organization determines that it will re-apply, the provider organization must initiate the endorsement process by submitting the complete endorsement application to the endorsing agency.

The endorsing agency shall notify the provider within 10 calendar days following the Clinical Interview regarding the status of the Clinical Interview portion of the endorsement review. The notification letter shall specify one of the following actions:

- (1) Provider meets the clinical interview requirements and the onsite review is scheduled; or
- (2) Provider does not meet the clinical interview requirements and endorsement is denied.

The notice of denial shall include a statement of the provider's appeal rights at the local and state level. Upon request for reconsideration at the local level, the Clinical Director, or appointed designee, of the endorsing agency shall review the request for reconsideration.

## **2C. Onsite Review**

The onsite review shall be completed within 20 calendar days of the notification of the completion of a successful Clinical Interview. The onsite review shall include a review of each service the provider seeks to provide, at each site where the provider seeks to provide a service.

The endorsing agency shall use the standardized endorsement check sheets during the onsite review to verify the infrastructure that supports the documentation reviewed during the desk review as well as the sources of evidence indicated on the standardized check sheet related to:

- (1) Business entity verification requirements (note – the endorsing agency only confirms that the provider has met business entity verification requirements)
- (2) Staffing requirements, including staff names, qualifications, and positions
- (3) Service type/setting requirements
- (4) Clinical requirements
- (5) Documentation requirements

In all situations where the provider has not previously provided the service(s) and therefore has no completed consumer records, the endorsing agency shall complete the onsite review using the check sheets excluding those items requiring components of consumer records.

If at any time during the endorsement process it is determined that the provider agency is not in good standing with DHHS and/or any LME, the endorsing agency shall terminate the endorsement process.

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

The provider may reapply at any time after good standing with DHHS and/or LME(s) has been re-established. If the provider organization determines that it will re-apply, the provider organization must initiate the endorsement process by submitting the complete endorsement application to the endorsing agency.

The endorsing agency shall notify the provider regarding the status of the onsite review portion of the endorsement process within 10 calendar days following the onsite review. The notification letter shall indicate the following:

- (1) Provider meets the onsite review requirements and endorsement is granted; the Standard Agreement shall be sent to provider for signature; or
- (2) Site/service endorsement is denied on the basis that the provider is not in compliance with the requirements to provide the service(s) for which application was made.

Where site/service endorsement is denied, the notice shall include a statement of the provider's appeal rights at the local and state level.

The endorsing agency shall only grant the provider organization site/service endorsement once it has been determined that the provider organization has successfully met the desk review, Clinical Interview and onsite review requirements.

### **3. 60 Day Follow-up Review**

The provider shall notify the endorsing agency, via return receipt/certified mail, of its receipt of the DMA enrollment letter within 10 calendar days from the date of the DMA enrollment letter. The endorsing agency shall monitor the provider's endorsed site within 60 calendar days from the date of the DMA enrollment letter. This monitoring shall include a review of compliance with the service definitions and sources of evidence indicated on the standardized check sheet items.

The 60 day follow-up review shall include **but not be limited to** a review of documents related to the following elements:

- (1) Provider requirements: provider staff training on DHHS and LME requirements for appropriate documentation, forms, prior authorizations, and continued insurance coverage per the Standard Agreement;
- (2) Staff requirements: complete listing of all staff names, qualifications, and positions (note that all staff required for a service per the service definition are required to be employed and providing the service) to ensure staff are fully trained on the goals and objectives of the service and the strategies and techniques used, Medicaid RA Forms, Paid claims, ensure staff meet training requirements per definition;
- (3) Service type/setting requirements: review service notes to ensure services provided are appropriate to consumer's needs based on diagnosis, person centered plan, Medicaid RAs, etc.;
- (4) Clinical requirements: clinical reviews, staff supervision provided, staff interviews; and
- (5) Documentation requirements: - minimum requirements for compliance for payment per Medicaid provider enrollment agreement; all documentation must support the legitimacy of billing; a review of paid claims to determine if billing supported by service notes.

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

Providers are required to be serving consumers within 60 calendar days from the date of the DMA enrollment letter. If a provider has not accepted consumers and delivered services to consumers within 60 calendar days from the date of the DMA enrollment letter, endorsement shall be involuntarily withdrawn. If no consumers are served during any consecutive 120 day period, the provider's endorsement shall be involuntarily withdrawn by the endorsing agency.

#### **4. Provider Failure to Meet Business Entity Verification and/or Service Endorsement Requirements**

If a provider fails to meet business entity verification requirements, business entity verification shall be denied and the endorsing agency shall notify the provider, via return receipt/certified mail, of the basis for the failure to meet requirements; a copy of the denial letter shall be sent to the DMH/DD/SAS. The provider must wait six months before re-applying for business entity verification with **any** endorsing agency. The notice shall include a statement of the provider's appeal rights at the local and state level.

A provider that achieves business entity verification but fails to meet site/service specific requirements must wait 6 months to re-apply for that service with that specific endorsing agency. The provider may, however, apply for that site/service endorsement through another endorsing agency at any time. The provider may also apply for **other** services through the LME where it failed to meet the specific site/service endorsement. If the provider organization determines that it will re-apply, the provider organization must initiate the endorsement process by submitting the complete endorsement application to the endorsing agency.

#### **5. Letter of Endorsement**

When a provider is determined to have met all the endorsement requirements, the endorsing agency shall send, via return receipt/certified mail, the standard agreement to the provider for signature (see page 16 of 17, section 8 of this policy) within 10 calendar days of the successful completion of the onsite review. The standard agreement is maintained on the DMH/DD/SAS website at [www.ncdhhs.gov/mhddsas](http://www.ncdhhs.gov/mhddsas). The provider has 15 calendar days to return the signed standard agreement. Evidence of adequate insurance coverage, as noted in the standard agreement, shall be submitted with the signed standard agreement.

Upon receipt of the signed standard agreement, the endorsing agency shall notify the provider of the status of its endorsement within 10 calendar days of receipt of the signed standard agreement, utilizing the standard Notification of Endorsement Action (NEA) letter; a copy of the NEA letter shall be sent to the DMH/DD/SAS, Accountability Team, via electronic submission at [endorsements.accountability@dhhs.nc.gov](mailto:endorsements.accountability@dhhs.nc.gov). The letter must indicate the beginning and expiration date of the endorsement period.

The provider must complete the online provider enrollment application electronically and submit the supporting documentation to DMA's Provider Enrollment Section electronically once endorsement is granted. An endorsed provider **must** be directly enrolled by DMA prior to delivering or billing for Medicaid-covered services. The provider will not be reimbursed by NC Medicaid for any services requiring endorsement that are delivered prior to the endorsement by the endorsing agency and enrollment as a provider with DMA to provide Medicaid-reimbursable mh/dd/sa services (i.e., Community Intervention Services).

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

Endorsement and Medicaid enrollment for services other than CAP-MR/DD is site and service specific and shall be honored by all endorsing agencies.

## **6. Denial of Endorsement**

A provider's application for endorsement may be denied for any of the following reasons:

- (a) The provider fails to comply with endorsement requirements;
- (b) The provider does not meet the requirements identified in clinical policy specific to the service definition;
- (c) The provider fails to meet all applicable requirements of Medicaid policy and regulations, federal and state licensure and certification requirements for the type of service for which application was made;
- (d) The provider has relationships with excluded/debarred individuals or entities. An endorsement application shall be denied if an owner, managing employee, authorized official, medical director, supervising physician or other individuals affiliated with the provider organization are excluded from Medicaid participation in other federal health care programs or debarred from federal procurement. A denial may be reversed if the provider submits documentation that the relationship with the excluded or debarred individual or entity has been terminated within 30 calendar days of the notice of denial.
- (e) The provider entity or any of its owners have felony convictions determined to be detrimental to the best interests of the program. A denial may be reversed if the provider submits documentation that the relationship with the convicted individual has been terminated within 30 calendar days of the notice of denial;
- (f) The information provided during the application process was false or misleading such that disclosing that information would have resulted in a denial of endorsement;
- (g) At the time of the scheduled clinical interview, the provider has not hired all staff members to meet the staffing requirements of the service definition;
- (h) On the basis of the clinical interview, the provider does not meet clinical interview requirements;
- (i) On the basis of the onsite review, it is determined that the provider is not equipped to provide services for which application was made;
- (j) The applicant does not have a physical address where services can be provided, does not have a place where client records can be stored in accordance with HIPAA requirements or does not meet other requirements necessary to do business; or
- (k) The applicant has not obtained the required state and local licenses, permits or authorization including, but not limited to, professional and facility licenses to perform the services it intends to provide.

The provider shall be notified that endorsement has been denied via the standard NEA letter. The basis for the denial of endorsement noted on the NEA letter shall be consistent with the reasons noted in this policy. The notice/letter shall be signed by the endorsing agency's Chief Executive Officer (CEO) or appointed designee with a copy submitted to the DMH/DD/SAS Accountability Team.

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

## **7. Withdrawal of Endorsement**

Withdrawal of endorsement may be initiated by the endorsing agency, DMH/DD/SAS, the Secretary of DHHS, or the endorsed provider organization. There are two types of endorsement withdrawals: voluntary and involuntary.

A voluntary withdrawal of endorsement shall be initiated by the endorsed provider. A provider's endorsement may be voluntarily withdrawn if the provider is in "Good Standing" with the endorsing agency at the time of the request. The provider must submit a written request, signed by its Chief Executive Officer or Chief Operating Officer, stating the reason for the withdrawal and agreement to the voluntary withdrawal of endorsement.

If the endorsed provider is voluntarily withdrawing endorsement of only one service and will continue to maintain endorsement for other services, the endorsing agency shall amend the standard agreement and issue the NEA letter reflecting that change to the provider.

Involuntary withdrawal of endorsement shall be initiated by the endorsing agency for any of the following reasons:

- (a) The provider is no longer compliant with endorsement requirements;
- (b) The provider no longer meets the requirements identified in clinical policy specific to the service definition;
- (c) The provider has not accepted consumers and delivered services to consumers within 60 calendar days from the date of the DMA enrollment letter.
- (d) The provider fails to serve consumers during any consecutive 120 day period;
- (e) The provider is found to not meet all applicable requirements of Medicaid policy and regulations, or federal and state licensure and certification requirements for the type of service the provider agency is endorsed to deliver;
- (f) Information submitted regarding business entity verification is substantially inaccurate;
- (g) The provider fails to achieve National Accreditation pursuant to NCGS § 122C – 81;
- (h) The provider's National Accreditation status lapses or is withdrawn;
- (i) The provider's licensure is not current;
- (j) The provider fails to comply with any provisions of the standard agreement including, but not limited to, failure to maintain insurance coverage;
- (k) The provider fails to meet other conditions of participation set forth by DMA;
- (l) The provider fails to comply with any of the following as noted in NCGS § 122C-115.4(b)(2)
  - Meet defined quality criteria.
  - Adequately document the provision of services.
  - Provide required staff training.
  - Provide required data to the LME.
  - Allow the LME access in accordance with rules established under G.S. 143B-139.1.
  - Allow the LME access in the event of an emergency or in response to a complaint related to the health or safety of a client; or
- (m) There is evidence of substantial failure to comply with current rules or NC General Statutes which apply to the provider agency or the endorsed service.

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

If the provider's endorsement is involuntarily withdrawn for any of the reasons listed above, the provider's standard agreement shall be withdrawn by the endorsing agency and all other endorsing agencies will be notified if applicable.

The endorsing agency shall notify the provider of the intent to withdraw endorsement via the standard NEA letter. The basis for the withdrawal of endorsement noted on the NEA letter shall be consistent with the reasons noted in this policy. The notice/letter shall be signed by the endorsing agency CEO or appointed designee.

**Once the provider's appeal rights with the LME have been exhausted or the timeframe for request of reconsideration has expired**, the endorsing agency shall issue the following notifications about the withdrawal of the provider's endorsement.

- a copy of the notice/letter shall be electronically submitted to DMH/DD/SAS, Accountability Team at [endorsements.accountability@dhhs.nc.gov](mailto:endorsements.accountability@dhhs.nc.gov);
- a copy of the notice/letter shall be electronically submitted to DMA at [endorsement.dma@lists.ncmail.net](mailto:endorsement.dma@lists.ncmail.net);
- a copy of the notice/letter shall also be mailed to the Chief of Mental Health and Certification Section at Division of Health Service Regulation (DHSR) if it is a service subject to DHSR licensure. The mailing address is 2718 Mail Service Center, Raleigh, NC 27699-2718; and
- notification to other LMEs statewide of the withdrawal of endorsement.

If the endorsing agency is withdrawing endorsement of only one service and the provider will continue to maintain endorsement for other services, the endorsing agency shall amend the standard agreement and issue the NEA letter to the provider.

In the case of a withdrawal of business entity verification, the endorsing agency shall notify DMA to determine any other site/service specific endorsements which are affected by the withdrawal of the business entity verification. The endorsing agency shall notify other LME(s) statewide of the withdrawal of business entity verification. Such a withdrawal precludes the provider agency from being endorsed or enrolled for **any** mh/dd/sa Medicaid reimbursable service.

If the provider's business entity verification has been withdrawn, the provider must wait 6 months to request business entity verification from **any** endorsing agency. If a site/service endorsement is withdrawn, there shall be a 6 month waiting period before the provider can reapply for site/service endorsement for that service with that specific endorsing agency.

In the event of the withdrawal of endorsement, the LME is responsible for ensuring that the provider immediately and adequately transitions existing consumers to an endorsed provider per the consumer's choice. The provider shall not accept any new admissions or referrals during the transition period. For any directly enrolled NC Medicaid Provider who appeals a withdrawal of an endorsement, or an endorsement that was not renewed by the endorsing agency, any services provided after the date of withdrawal shall be subject to recoupment by DMA. Services may not be provided during the pendency of any appeal to either the Office of Administrative Hearings or any state or federal courts.

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

All providers, including those whose endorsement was voluntarily or involuntarily withdrawn, are responsible for maintaining custody of the records and documentation to support service provision and reimbursement for the required retention period for publicly funded mh/dd/sa services.

#### **8. Standard Agreement and LME Operations Manual**

The endorsing agency shall enter into a standard agreement (i.e., MOA) with an endorsed provider organization. The standard agreement and Operations Manual contain the information and materials, such as uniform forms, provisions and statewide requirements for all endorsed Medicaid providers. The Operations Manual is available at <http://www.ncdhhs.gov/mhddsas/statpublications/manualsforms/forms/operationsmanual4-22-05template.pdf>

#### **9. Reconsideration and Appeal Rights of the Provider**

A provider whose business entity verification and/or site/service endorsement status is denied or withdrawn by an endorsing agency must first request a local reconsideration of the decision by the endorsing agency prior to filing an appeal to the state. The endorsing agency shall inform the provider in writing, of all appeal rights at the local and state level and the required filing time frames.

#### **10. Endorsement of Providers within Forty Miles of North Carolina**

A provider seeking enrollment in the North Carolina Medicaid program as an In-State or Border Provider of mh/dd/sa services to consumers from North Carolina, (i.e., those providers whose physical location is within the limits established by the DMA for treating an out-of-state provider as in-state for the purposes of Medicaid billing), shall complete an In State/Border provider application and meet the requirements for endorsement as set forth in this policy.

An out-of-state provider shall apply for endorsement with an endorsing agency per the stated policy. The endorsing agency shall be an LME whose catchment area is contiguous with the county or catchment area of the out-of-state provider, or one that has a consumer that has selected the out-of-state provider as his or her choice of provider.

A provider applying for endorsement of a service that would require facility licensure if the provider were located in North Carolina, must meet the health, safety and building requirements established for provider's of an equivalent service in the state in which the provider is located. The endorsing agency shall contact the oversight agencies in the state the provider is located to determine if the provider meets the requirements.

#### **11. CAP-MR/DD**

Endorsement for CAP-MR/DD is statewide and reviewed only once per service. When a provider adds a CAP-MR/DD location and not a new service, the provider must sign a standard agreement (i.e., MOA) with the LME in the new catchment area.

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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE  
ABUSE SERVICES  
POLICIES AND PROCEDURES**

---

**12. Process for LME Endorsement**

An LME that wishes to provide and seek reimbursement for Medicaid Community Intervention Services must follow the endorsement process as stated in this policy. In addition, the LME must submit a written request and receive a waiver approval from DHHS to provide direct services. LMEs will only be considered for a waiver to provide direct services(s) if there is evidence that community capacity is inadequate in the catchment areas for that given service and the LME is working aggressively to recruit and maintain adequate provider capacity. An LME plan indicating service needs, gaps, and possible strategies to assure adequate community capacity will be considered as evidence.

The LME must be directly enrolled with the DMA and is subject to the endorsement process by DHHS. The DMH/DD/SAS shall review applications and conduct the desk review, clinical interview and onsite reviews of LME services for endorsement. Endorsement reviews shall be performed by a two member team of the DMH/DD/SAS staff. The timeframes for the LME endorsement process are the same as the timeframes stated in this policy for provider endorsement.

LME endorsement will only be granted on a temporary basis, as specified in the LME waiver. Prior to the expiration of the waiver, the LME must request an extension to the waiver to continue to provide the service. The request must include a justification to continue providing the service along with a brief description of attempts to build community capacity. The letter shall be submitted to the DMH/DD/SAS LME Systems Performance Team Leader.

The Secretary of DHHS shall make the final decision regarding waiver approvals and time frames of approvals.